

Health Insurance Summary and Cost Information

- This document summarizes this plan's costs and commonly used benefits.
- The policy is your insurance contract. Read the policy carefully. It explains how to use the plan and duties of both you and your insurer. You can get a copy of the policy at www.insurancecompany.com or you may call 1-800-XXX-XXXX.

Important Questions	Answers	Why this matters
What premium amount do I pay? ¹	\$550 monthly for individual ²³	The premium is the amount of money that must be paid for health insurance.
What is the plan deductible?	Medical \$2,000/indiv./year Prescription drug \$500/indiv./year Mental health \$1,000/indiv./year Preventive \$0/indiv./year <i>Important: There may be other deductibles.</i> ⁴	The deductible is the amount of money you must pay for health care covered by this plan before your insurer begins to pay. You may have separate deductibles for different health care services. The largest deductibles are listed here, but there may be others.
Is there an out-of-pocket limit each year?	Yes \$5,000 for preferred provider charges / year. \$10,000 for non-preferred provider charges / year.	The out-of-pocket limit is the most you will be required to pay each year for services covered by health insurance. You may have separate out-of-pocket limits for different health care services.
What is <u>not</u> included in the out-of-pocket limit?	Premium Pharmacy charges Non-participating provider charges in excess of the allowed amount	The amount of money you pay for these charges do not count toward out-of-pocket limits.
Are there lifetime or yearly maximums on any benefits?	Yes. \$7,500 lifetime -durable medical equipment \$10,000 lifetime – hospice & respite care 20 physical therapy visits / year 300 miles ground ambulance / year	Health insurance may limit services you receive on a lifetime or annual basis, even if your own medical need is greater than this limit. [Need to review this explanation]

¹ Note: For a family policy: "What premium amount does my family pay?"

² Note: Employer may have to complete this field to accurately show premium the consumer pays. Subgroup may develop recommendations on process.

³ Note: For a family policy, this field may say "\$900 monthly for family".

⁴ Note: The 4 (?) most significant deductibles should be listed. If not all deductibles are shown, the note that there may be other deductibles must appear.

Does this plan require me to use a network?	Yes, this plan uses Preferred Providers. ⁵ You may use doctors or health care providers that are not Preferred Providers, however you may pay more. For a list of Preferred Providers, see www.insurancecompany.com or call 1-800-XXX-XXXX.	The doctor or other health care provider you choose may affect the amount of money you have to pay. If you do not use a doctor or other health care provider in this network, your health insurance may not pay at all, or you may pay higher costs for their services.
How can I see a specialist?	You do not have to get a referral to see a specialist that is a preferred provider. If you see a specialist that is not a Preferred Provider, you may be required to pay more.	You may be required to select a primary care doctor to coordinate your health care. You may be required to get permission to see a specialist. You may also be required to see a specialist that is part of the plan's network. If you don't, your health insurance may not pay at all, or you may pay higher costs.

⁵ Note: Or Participating Providers, In-network Providers, etc.

Covered Services, Cost Sharing, Limitations and Exceptions

The chart shows common examples of how much you pay for health care under this plan. It also shows the limits and exceptions for each covered service. [Need to conform based on the variation in plan/coverage types.]

Some things you need to know to understand this chart:

- Coinsurance is the part you pay (for example, 20%) of the amount due.
- [Definitions of preferred/non-preferred providers. You pay more for non-preferred providers.]
- The allowed amount is the maximum amount on which payment will be based for covered services. If a non-preferred provider charges an amount greater than the allowed amount, you are responsible to pay the difference.
- [Medical necessity and pre-authorization explanations in order to get benefits below]

Common medical events	Services you may need	Your costs if you use a		Limitations and exceptions
		[Preferred Provider]	[Non-preferred provider]	
If you visit a health care provider's office or clinic	Primary care physician office visit	\$20/visit	\$50/visit	
	Other practitioner visit ⁶	\$20/visit	\$50/visit	
	Specialty physician office visit	\$35/visit	\$75/visit	
	Preventive care visit/immunization	No charge	\$50/visit	
If you have a test	Diagnostic test (x-ray/blood work)	20% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	\$10/prescription	\$10/prescription	
	Preferred brand drugs	\$25/prescription	\$25/prescription	
	Non-preferred brand drugs	\$50/prescription	\$50/prescription	
	Other services (e.g., radiation)	20% coinsurance	50% coinsurance	
If you have outpatient surgery	⁷			
If you have a hospital stay	Facility fee	20% coinsurance	50% coinsurance	
	Physician / surgeon fees	20% coinsurance	50% coinsurance	
	Other services (e.g., radiation)	20% coinsurance	50% coinsurance	

⁶ Note: Intended to include chiropractor, acupuncture, etc.

⁷ Note: Need common services to list.

Common medical events	Services you may need	Your costs if you use a		Limitations and exceptions
		[Preferred Provider]	[Non-preferred provider]	
If you have a severe accident (other than a work-related accident)	Emergency room fees	\$100/visit	\$100/visit	
	Emergency medical transportation	No charge	No charge	
	Urgent Care			
If you have mental health or substance abuse needs	Substance abuse outpatient services	\$20/visit	\$50/visit	
	Substance abuse inpatient services	20% coinsurance	50% coinsurance	
	Mental health office services	\$20/visit	\$50/visit	
	Mental health inpatient services	20% coinsurance	50% coinsurance	
If you become pregnant	Prenatal and postnatal care	\$20/visit	\$50/visit	
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	
If your child needs oral or vision care	Eye exam	\$20/visit	\$50/visit	1 exam per year
	Glasses	Limited	Limited	Maximum \$100/year.
	Dental check-up	Not covered	Not covered	
If you need specialty injectable drugs	Doctor-administered	\$25/prescription	\$50/prescription	
	Self-administered	\$25/prescription	\$50/prescription	
If you have a long-term recovery	Home health care (care ordered by a physician that you receive at home)	20% coinsurance	50% coinsurance	
	Rehabilitation services (services to regain or gain skills lost or impaired due to illness)	20% coinsurance	50% coinsurance	
	Skilled nursing care (care by a registered nurse or nurse practitioner outside a hospital)	20% coinsurance	50% coinsurance	
	Durable medical equipment (equipment and supplies ordered by a health care provider)	20% coinsurance	50% coinsurance	
	Hospice service (care you receive during the last	20% coinsurance	50% coinsurance	

Common medical events	Services you may need	Your costs if you use a		Limitations and exceptions
		[Preferred Provider]	[Non-preferred provider]	
	<i>stages of a terminal illness)</i>			

Excluded Services: The following services are not covered. You must pay the full cost to receive these services.

Dental services

Vision services

Coverage Facts:

Renewability:

- You can keep this insurance as long as you pay your premium unless one or more of the following events happen: (1) you commit fraud, (2) the insurer stops offering services in the state, (3) you move outside the coverage area, (4) you or your employer's membership ends in an association that sponsors this health insurance, but only if termination is unrelated to the health status of any covered person; or (5) your employer/sponsor changes insurance carrier.

Your Grievance and Appeals Rights:

- You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. Include a sentence as to the consumer's rights. For more information on the appeals process, call your state office of health insurance customer assistance at: 1-800-xxx-xxxx or visit: www.Xxxxxxxxxxxxxx.gov.

Required Federal Government Disclosures:

- This plan [provides/does not provide] minimum essential coverage. If the plan does not provide minimum essential coverage, you may have to pay tax penalty.
- This plan will [pay/not pay] at least 60% of the total allowed costs of the benefits listed in the policy.

Questions: Call 1-800-xxx-xxxx or visit us at www.dogoodinsurer.com